Proceedings

National Summit on School-Based Outreach for Children's Health Insurance Programs

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Proceedings from the National Summit on School-Based Outreach for Children's Health Insurance Programs

Opening

The National Summit on School-Based Outreach for Children's Health Insurance Programs (Medicaid and SCHIP), took place November 17 - 18, 1999 in Washington, D.C with more than 300 individuals attending. The Summit opened with welcoming remarks from **Mr. Thomas Morford, Deputy Administrator of the Health Resources and Services Administration (HRSA) and Ms. Nancy Ann DeParle, Administrator of the Health Care Financing Administration (HCFA)**. HRSA funded the Summit with the financial support of the Kellogg Foundation who ensured the participation of community-based individuals. Four Cabinet Secretaries attended the opening of the Summit and provided a welcome and comments about the importance of partnering with school systems to reach and enroll children in health insurance programs.

Secretary Donna Shalala of the Department of Health and Human Services expressed her enthusiasm for the Children's Health Insurance Program and acknowledged the hard work ahead for all at the Summit to get kids enrolled. She highlighted her Department's activities with the 1-877-KIDSNOW toll-free line, the regional conference calls, and face-to-face meetings that preceded the Summit to find out what is already known about successes and challenges to school-based outreach. Secretary Shalala described the partnerships she has forged with the Attorney General and Secretary Riley on the "Back to School Campaign" to get kids enrolled in CHIP and Medicaid. She left the audience with the message that "CHIP is here to help–and we're here to help CHIP."

Attorney General Janet Reno followed Secretary Shalala and opened by answering the question that many were asking, "why is the U.S. Attorney General interested in getting children health insurance coverage?" She spoke of her experience in Miami as State's Attorney where she repeatedly read pre-sentence reports on offenders who had suffered from untreated mental and physical illnesses, contributing, she believes to their later criminal activity. She believes that if those children had been able to access health care and other supports, many, if not most would not have shown up in files on her desk and engaged in the juvenile justice system. She highlighted the Department of Justice's "Five Goals For Kids" partnership that aims to enroll 500,000 kids in CHIP and Medicaid as one of its goals.

Department of Education Secretary Richard Riley discussed the importance of children having their health care needs met for them to succeed in school. He stated that more than 200 million school days a year are missed by children and adolescents

because of health problems. Secretary Riley highlighted his Department's "Insure Kids Now! Through Schools" Campaign where all superintendents and thousands of elementary school principals were sent information on ways their schools could promote health insurance enrollment. He emphasized the importance of developing new ways for health officials to support and work effectively with school leaders to maximize everyone's limited resources.

Secretary Dan Glickman of the U.S. Department of Agriculture closed the welcoming remarks. He noted that while USDA is best known as the government agency that supports America's farmers and ranchers, two-thirds of their budget is devoted to food and nutrition programs like Food Stamps, WIC, and School Meals. After the Department of Education, USDA has the largest presence in American schools of all Federal government agencies. Because of that presence, USDA is uniquely positioned to encourage participation in CHIP. They have done this through their website and creating a new prototype free and reduced-price school meal application. Through that application, parents and guardians may request more information about CHIP and give consent to have their application information shared with CHIP administrators. Since a disproportionate number of uninsured children come from immigrant families, USDA is taking the next step. The new application will be available in 10 different languages for the 2000-2001 school year. There is no reason language should be a barrier to health care. Secretary Glickman closed by emphasizing how important it is for government agencies to champion each other's efforts and initiatives so that America's children can lead healthy, prosperous, and enriching lives.

Keynote

Marian Wright Edelman, founder and Executive Director of the Children's Defense Fund, keynoted the Summit. She began by highlighting the negative effects poor health can have on a child's ability to learn, such as vision and hearing problems or asthma. She then went on to discuss the unique role schools can play in providing linkages between multi-level programs such as free and reduced price lunch programs and school-based health clinics. In addition, schools are in a unique position to reach families because children are there most often and because families tend to trust school officials and teachers. She highlighted the efforts of several States where schools are engaging in outreach, and reiterated the message that schools cannot do this alone. It is important for the States to work on making their application process and their programs easy to understand and accessible to all needy families. She then encouraged States to continue their efforts and focus on; the education of families about their options for health insurance, the improvement of computer tracking systems for eligibles and enrollees, the approval of 12 month continuous eligibility, and targeted outreach to immigrant and minority communities. She also highlighted some of the partnerships CDF has been

engaged in around CHIP, specifically with Martha Stewart Living and Kmart Corporation, as well as some local efforts in New York and Ohio. She concluded by reminding the audience that this is an unprecedented opportunity to insure children, and that health care is a right not a privilege.

Plenary Session: School-Based Outreach–The Chicago Experience

Sue Gamm, Chief Specialized Services Officer for the Chicago Public Schools and Matt Powers, Administrator of the Division of Medical Programs, Illinois Department of Public Aid, described the Chicago experience with school-based outreach. The Chicago Public School System enrolls 434,000 students, 83 percent of whom are classified as low-income by school lunch data. CPS health statistics for Chicago showed that 25 percent of students did not have regular medical care and that the city had the highest mortality rate for pediatric asthma in the country.

The school system utilized Geographic Information System (GIS) mapping techniques to identify schools with at least 300 children eligible for but not enrolled in Kidcare (their CHIP program) or KidCare Assist (their Medicaid program). Those schools were targeted for a biannual "Report Card Day" where there is almost 100 percent parent attendance. The school system used press, radio ads, and commercials to raise awareness prior to the day. Early assessments of this event were disappointing. The first "Report Card Day" used the State's 12-page application which may have led to the initial problems. For the second Day held about six months later, the school district used the State's new, shortened application, sent out applications before the event, ensured that schools had KidCare coordinators, provided education regarding the documentation required to complete an application, and provided information on immigration concerns.

The effort produced over 9,000 applications, 75 percent of which were incomplete when submitted. The school district tracked 3600 of those and found that 20 percent were completed within the first month, 70 percent within four months and that 18 percent were withdrawn by the applicants. Lessons learned by the Chicago Public School System include:

- it takes between two and three family contacts to get a completed, approved application and that face to face contact is critical;
- providing monetary compensation for successful applications helps;
- a single application for both CHIP and Medicaid helps;
- presumptive eligibility is important;
- most of the families applying had low literacy levels;
- there is a general lack of understanding among families of how insurance works and why it I
- important;
- families continue to be suspicious of government but will respond to trusted, local sources for information and assistance; and

- "passive" promotion does not work.

Breakout Sessions

A series of concurrent breakout sessions followed the presentations and remarks.

In **Breakout 1, Holding Special Events**, Kathy Lally of the United Way, Washington, D.C. and Jennie Hamilton, Oregon Primary Care Association presented information about creating special outreach events in schools and communities. Ms. Lally discussed the United Way's participation in the Back-to-School Campaign from September 19 through October 4 in over 25 cities across the country. Local United Ways in cities like Richmond, San Antonio, Orlando, Macon, and Denver coordinated with other partners to strategically place bus ads, mail information to families, canvass neighborhoods, and hold Back-to-School nights. From the over forty events that took place, planners learned with school events to:

- establish personal contact with the school principal;
- use trained volunteers and personnel;
- code applications for tracking;
- outreach prior to any event in the neighborhood around the school and in the school;
- establish a follow-up system after the event; and
- establish a toll-free line that is properly staffed.

Additionally, for community events the planners learned:

- the importance of promoting a clear message;
- that radio advertising is sometimes more effective than television;
- to make events fun; and
- to realistically assess the organizers' capacity to do outreach or enrollment or both.

Ms. Hamilton discussed the Street Teams public awareness campaign targeting Jackson County, Oregon's Hispanic families. The campaign combines a media component, with Spanish television and radio the most successful vehicles, and a face-to-face component lead by an AmeriCorps Promise Fellow working in the community. Ms. Hamilton found that the major barriers to accessing health insurance in that area were a lack of program awareness; fear of the system; language and communication; an overwhelming application process; low literacy levels among applicants; mixed messages; transportation; health care not being a priority until someone is sick; and an inability to pay premiums.

The lessons learned include:

- keeping the message clear, concise, and convincing;
- knowing the audience;
- not using acronyms; and
- having the message in the language of the audience and realizing that people need to hear the message repeatedly to remember it.

Ms. Hamilton also emphasized the importance of working with multiple partners from various aspects of the community. In planning a school event, ensure a variety of people on the planning

committee--from teachers to students to health outreach workers--and define a unified mission and clear message. The best methods for reaching Hispanic families included distributing posters and brochures in the places they live, work, and play; using Spanish radio and television but not newspaper advertising which was less successful; one-on-one contact; word of mouth; and schools and community events. It also helped to distribute a flyer prior to any event that listed the types of documentation needed to complete an application so families would come prepared.

In **Breakout 2, Reaching Adolescents**, Barbara Ritchen, Director of the Child, Adolescent and School Health Section of the Colorado Department of Public Health and Environment and Allison Staton of Health Care for All in Boston discussed their experiences in targeting outreach efforts to teens. Ms. Ritchen noted the importance of involving HRSA's Title V, Maternal and Child Health block grant staff as partners in any efforts to reach children and adolescents. She noted that State Adolescent Health Coordinators in particular are good resources for States regarding any provisions in their CHIP plans that focus on adolescents. She defined the "ABCs of Outreach to Adolescents" as:

- Access--using points of contact like school nurses, school-based health centers, free and reduced price lunch programs, report card pick-up days, parent-teacher conferences;
- Building Relationships--stress the common goals between agencies and organizations; establish personal relationships; involve teens and their families in all steps of decision making; and
- Connecting with teens and their families--each teens where they are like malls, parks, homeless shelters, mainstream and alternative schools, although often by teenage years there is less parent involvement in schools; ask teens what the barriers are; talk to teens about how health insurance relates to their use of Planned Parenthood or Community Health Centers; use teens to do peer outreach; explain the issues of confidentiality to them; educate families about the importance of health insurance, and how to use a managed care system.

Allison Staton works with the Coaches Campaign, a teen-designed and teen-run campaign targeting athletic coaches in schools and promoting the education of student athletes about the importance of health insurance. With money from an advertising agency and a photographer that works with Nike, the teens designed an in your face and aggressive campaign. Ms. Staton emphasized the importance of involving teens in all aspects of the process of designing the outreach campaign because they are so marketing savvy and attuned to trends.

From the discussion, it was noted that the health academies in California permit students to receive academic credit for participating in CHIP and Medicaid outreach activities. In many states, teens are required to complete community service hours to graduate and peer to peer CHIP and Medicaid outreach would certainly qualify. City Year volunteers could also be contacted to facilitate peer to peer programs; Seattle is currently trying this approach.

Other issues:

- there is a need to remove the misconception that insurance offered through the school does not last through the summer;
- homeless children and adolescents who are not in the schools must still be reached;

- teens recently released from the juvenile justice system need to be informed about their health insurance options; and
- it is important to be aware in designing and implementing strategies that dealing with adolescent health often involves uncomfortable issues for many people.

Talley Baratka of Action Alliance for Virginia's Children and Youth; Nancy Sheppard from Higher Horizons Head Start in Fairfax, Virginia; and Jenny Kattlove from the Children's Defense Fund-Ohio all presented in **Breakout 3, Reaching Preschoolers**. Ms. Baratka's organization sponsors the Greater Richmond Outreach for Wellness (GROW) project in which she works with private child care centers in Richmond, providing training and an incentive program to encourage center staff to discuss CHIP and Medicaid with their customer families.

She suggested that successful outreach and enrollment requires:
- inviting community members, particularly child care providers to participate early in the outreach and enrollment process;
- completing background research on the population to be served before approaching community members for assistance;
- establishing trust with community members;
- listening to concerns of community members and being flexible enough to adjust outreach methods according to their suggestions;
- developing easily understandable outreach materials; and
- developing an efficient tracking strategy.

At Higher Horizons Head Start, each family works with a family service advocate to complete a Family Partnership Agreement. As part of that process, information is shared on CHIP and Medicaid and the advocate can help families complete the health insurance enrollment applications. In addition, Medicaid outreach workers attend the Head Start enrollment fair to provide information and assist with applications.
Ms. Sheppard outlined a number of challenges that exist in enrolling families in CHIP and Medicaid:
- ensuring that families are recertified;
- assuaging the fears of immigrants that enrolling their children in either program will affect their immigration status;
- ensuring adequate funding of the programs for all those eligible;
- helping families understand the difference between "payer" and "provider"; and
- promoting the enrollment of families in the programs when inadequate numbers of providers exist to serve them.

The Children's Defense Fund-Ohio is implementing a local outreach project in Columbus, Ohio (Franklin County) to help child care providers inform families and enroll them in Healthy Start Plus, that county's CHIP program. After running the campaign, Franklin County determined that:
- families want assistance with completing the insurance applications from trusted sources like health care providers;
- the application process was more difficult for families than expected;

- successfully generating awareness about the opportunity for enrollment did not necessarily ensure actual enrollments;
- it is effective to work in tandem with child care centers and other places outside of the home where children are cared for to enroll them in health insurance;
- it is effective to use target populations like siblings of targeted children, as a segue to other eligible populations;
- it could be effective to coordinate health insurance enrollment with regular enrollment at a child care center; and
- it is important to help families understand what happens to their applications after they complete them.

One attendee suggested that Head Start and Healthy Start combine their applications and many agreed that would be feasible.

Julia Lear, Program Director of Making the Grade and Pat Hauptman a Pediatric Nurse Practitioner and consultant for School-Based Health Centers in Baltimore, Maryland shared their experience in **Breakout 4, Reaching Kids Through School-Based Health Clinics and Providers**.

Making the Grade is a Robert Wood Johnson Foundation funded grant project that makes funds available to support State-community partnerships to establish comprehensive school-based health centers. Ms. Lear stated that School Based-Health Centers (SB-HC) make an excellent base for outreaching to children about CHIP and Medicaid because it is in their self interest to insure clients. If children and adolescents are not covered by insurance, the school does not get paid for their care; SB-HC want to be good health care providers and when they need to refer children to outside a consultant, if they are not insured, it is very difficult for the center to get consultations; and SB-HC are committed to ensuring a healthy community, not just caring for individuals.

Ms. Lear outlined the status of the nation's school health clinics. She reported on Making the Grade's survey on reaching children, which learned that reaching families and children through one-on-one contact instead of sweeping ad campaigns was most effective, and that little evaluation of effective outreach approaches had been conducted to know the most productive approaches for getting children enrolled and into care.

Ms. Hauptman outlined the three major goals of the Maryland School-Based Health Centers program as obtaining reimbursement for care, assuring medical follow-up, and preparing students to be good health care consumers. The challenges to the centers include managing the mobility of families and students; ensuring reenrollment after one year; helping families understand and enroll in traditional Medicaid versus CHIP; and providing assistance to SB-HC staff, who have multiple demands and need assistance in carrying out their outreach and enrollment related duties.

Attendees from both Wisconsin and San Jose, California commented that school districts feel this activity is important but that their first business is educating children and that there is

frequently little or no money or time for health activities. As well, to the extent that school staff conduct outreach and get kids enrolled, schools need someone to coordinate and ensure that children who are enrolled are receiving care and to follow-up to ensure that they stay in the health care system. Rhode Island suggested that States use Medicaid administrative matching funds to enroll children by paying a percentage of school outreach salaries; they currently pay five percent of those salaries. Arizona cannot use CHIP dollars for school-based health activities but has funded them with their State's tobacco settlement money. Indiana has a program in place to track outreach method for enrollees. They have found that most applicants are coming from hospitals and Federally Qualified Health Centers.

Richard Strauss, Health Care Financing Administration and Justin Kopca, Administration on Children, Youth and Families, presented the HHS perspective on federal funding opportunities for outreach in **Breakout 5, Public Funding**. Mr. Strauss discussed the fundamentals of Medicaid and CHIP financing. Medicaid is a Federal-State partnership with open-ended Federal funding if matched by State expenditures. With CHIP, States are limited by their allocation but receive an enhanced match from the Federal government. CHIP expenditures are divided between administrative and services with a 10 percent limit on administrative and other expenditures, including outreach expenditures. With a Medicaid expansion CHIP program, the 10 percent limit does not exist so States can put all administrative and outreach expenditures under Medicaid. States have options for CHIP outreach expenditure claiming. A State may claim all outreach costs to CHIP or allocate outreach costs among programs. States must submit cost allocation plans and under either option, outreach costs under CHIP must be less than 10 percent of total expenditures.

Presumptive eligibility exists to ensure that services that are provided are paid for no matter the eligibility determination outcome. For CHIP there is no explicit statute or authority for presumptive eligibility. Any presumptive eligibility costs under a CHIP program must be applied against the 10 percent limit. The $500 million TANF Fund resulted from the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) to ensure that the families losing welfare eligibility would still be screened for Medicaid eligibility following the delinking of the two programs. School-based administrative claiming is necessary for efficient and proper administration of Medicaid. Coordination between the State Medicaid agency, State Department of Education and school districts is important.

Justin Kopca explained that because of the 1996 PRWORA legislation, many children and families did incorrectly lose Medicaid eligibility. In addition, beyond not knowing they were still eligible for Medicaid, many families feared applying for public programs of any kind in the welfare reform climate. The PRWORA changed welfare benefits to a block grant with State-defined requirements for their programs. The program changed from Assistance for Families and Dependent Children (AFDC) to Temporary Assistance for Needy Families (TANF). The issue then is reaching these families. TANF funds can be used for CHIP and Medicaid outreach but not for general education or medical services.

The issue for a State is to answer these questions with respect to conducting outreach:

- How do you want to do outreach?

- What are the eligibility criteria, target audiences, etc.?
- Which funds do you want to use, i.e., TANF?
- What are the requirements and limitations associated with use of these funds?

Available resources on this issue include "Helping Families Achieve Self-Sufficiency" and "Families in Transition" from ACYF, resources on the web at www.hcfa.gov and www.acf.dhhs.gov, State agency contacts, and local and state advocacy groups. The Centers for Disease Control and Prevention has a school health finance database at www.cdc.gov/nccdphp/dash. Audience members noted that the upcoming guide on Medicaid administrative claiming in schools, which is rumored to be restrictive, is creating a dampening effect at the same time that schools are encouraged to continue or increase outreach efforts. Education representatives asked that the stringent requirements and limitations on administrative claiming also allow enough incentive to balance it out. Participants asked for examples of successful practices in States using TANF funds to conduct school-based outreach.

In **Breakout 6, Providing Enrollment Assistance**, Liddy Garcia-Bunuel from the Washington Health Foundation; Nano Poldosky, from Project Hope, Salt Lake City School District; Jon Anderson, Georgia Department of Family and Children's Services; and Robert Beardsley, New Mexico Medical Assistance Division presented. In Georgia, outreach in the schools included developing a PeachCare coloring book and disseminating it for younger children, teaming outreach staff with public health nurses when they go to schools to administer flu shots, working with Special Education Directors to increase awareness and allowing families to complete mail-in applications at locations like grocery stores. The outreach staff call back all families who have indicated interest.

The Seattle Public Schools use family support workers, school nurses and a City Year Americorp volunteer-coordinated youth peer education model to identify uninsured children. Methods for identifying children include a referral network, flyers with a tear-off, check off on lunch application, kindergarten registration, referral from coaches since kids must be insured to play sports, and teen health and wellness centers. School nurses also have access to the list of those who have the school's catastrophic health insurance and call those families to discuss other coverage options. Once identified, one-to-one family follow up occurs to help with the application; follow up after enrollment to assure coverage; and follow up to assure families have received medical assistance coupons.

The lessons learned by the Seattle experience include getting the commitment of the superintendent, building on existing systems instead of creating new systems, and individually recontacting families for recertification. The Seattle school system has addressed the issue of sustaining these efforts once current outreach funding lapses by incorporating these activities into the job description of the family support workers so there involvement will continue. The New Mexico enrollment assistance focus is on presumptive eligibility and Medicaid on-site application assistance. Head Start, child care centers, WIC offices, and Medicaid providers, including schools, are enrolled as presumptive eligibility and Medicaid on-site application assistance centers.

The Salt Lake City School District approach has been to utilize school secretaries, the Parents as Teachers program, and gang prevention/drug prevention programs to conduct outreach. School nurses are involved but are overextended with a high child to nurse ratio. English as a Second Language classes and school district employees are targeted for outreach and the Robert Wood Johnson grantee is conducting door-to-door canvassing (teams with at least one woman were most successful) and working with elected officials. Barriers to translating outreach to enrollment include the public charge issue; lack of time among educators; the crowd out provisions of CHIP that prohibit families from dropping more expensive private coverage and immediately receiving CHIP coverage; and adolescents perceiving themselves as immortal and not being interested health care consumers.

Overall successful strategies across the breakout session included:

- using presumptive eligibility;
- reaching parents during family-friendly hours;
- linking existing programs that families trust; and
- using English as a Second Language classes.

Needed resources include support and buy-in from education officials and money to pay for presumptive eligibility/on-site assistance to get a better product. Remaining barriers include the public charge issue and the time constraints of educators to participate in outreach, enrollment, and follow-up.

Barbara Semper, Food and Nutrition Services, U.S. Department of Agriculture; Catherine Digilio Grimes, State Director of Child Nutrition, Virginia Department of Education; Elena Chavez, Consumers Union, California and Felix Alvarez, Alum Rock School Board, San Jose, California presented the Federal and State government, school board and advocate perspectives on working with the school lunch program in **Breakout 7, School Lunch Partnerships**. The National School Lunch Program (NSLP) is a good link because many children that are eligible for free and reduced price breakfast and lunch are also eligible for CHIP and Medicaid. Schools are required to inform parents about the program each year and applications are in effect for one year. USDA tests only gross income with no assets test. Eligibility for free meals is up to 130% of the Federal Poverty Level for free meals and 130% to 185% for reduced price meals. USDA developed four prototype applications for States to use to allow for the information to be shared with Medicaid and CHIP agencies. An application with a separate CHIP form will be available in ten languages by Spring 2000. For more information on these programs check their website at http://www.fns.usda.gov/cnd/.

Confidentiality is a major issue for the NSLP because many other programs want the specific information by name of the child. The statute for the lunch program specifies that certain programs can have information about children eligible for free and reduced price meals. However, under the statute, USDA cannot currently release individual names to CHIP or Medicaid but can release aggregate data that can help with targeting outreach efforts. Parents can release their application information should they choose to and then receive information about CHIP and Medicaid. Immigration status is another critical issue. The NSLP does not consider immigration status for eligibility but for CHIP and Medicaid there are immigrant status

restrictions.

Challenges:

- there needs to be resolution of the immigration, varied income definition and confidentiality issues for the NSLP and CHIP and Medicaid to partner;
- partnership needs to occur on the State level between the State office of nutrition programs, State department of education and CHIP and Medicaid agencies;
- there is no NSLP funding to support CHIP outreach. The NSLP is generally not funded by local school boards. Standardized software is used by some school districts and may need to be altered to add information for CHIP;
- it is important to establish a clear system for sharing the list of families who express interest in getting information about CHIP/Medicaid via the school lunch application with the eligibility determination agency; and
- schools need more resources and staff to coordinate with families to better track the information.

Washington State piloted a duplicate paper application to over 50,000 families in which by filling out one application the information is transmitted to both the NSLP and CHIP/Medicaid applications. They have found this practice to be successful. New Jersey had a tear off sheet that was used with the school lunch application for parents to consent to the release of information. The list of consenting families was then sent to the Robert Wood Johnson Foundation Covering Kids grantee; it then sent people into the schools to provide information and assist with applications. In less than two months 1200 children were enrolled.

In **Breakout 8, Working with Community-Based Organizations**, Beth Felder from the South Carolina Department of Health and Human Services and Pat Redmond of Philadelphia Citizens for Children and Youth (PCCY) discussed their experiences partnering with community-based organizations to conduct outreach in schools and other venues. South Carolina held public hearings prior to the implementation of their CHIP program, Partners for Healthy Children, which is a Medicaid expansion. At those hearings, the State met with community organizations to form partnerships to strategize about and conduct outreach. Partners include:

- Family Connection--a group that focuses on children with special healthcare needs;
- Hope for Kids--a world-wide volunteer group sponsored by the Church of Christ;
- United Way;
- March of Dimes;
- faith-based groups;
- Federally Qualified Health Centers including rural health centers;
- county health departments who helped with the link to migrant and Native American families; and
- Covering Kids--three pilots in South Carolina focus on adolescents; Spanish-speaking population, and the Medicaid population in general.

Because Pennsylvania provided health insurance access for children before CHIP, they also had established community involvement in identifying and enrolling children in that program. Diverse groups with strong connections to schools, a commitment from school leadership and school nurses with experience and expertise were already in place when CHIP became available. They continue to have challenges in Philadelphia because of the large school system, high poverty, school nurses who have little extra time to focus on outreach for CHIP, paperwork requirements for applications, and trying to implement systematic enrollment campaigns. PCCY

multiple tools to assist school nurses and other community groups like an eligibility chart that is color coded to show Medicaid, free CHIP, and low-cost CHIP. It also lists local agencies to contact for assistance and more information. They have created a manual for school nurses entitled *Getting Health Care for Children and Teens: A Manual for School Nurses* in Southeastern Pennsylvania that presents various levels of outreach. It can be ordered for $10.00 from PCCY, Ester West, 7 Benjamin Franklin Parkway, Philadelphia, PA 19103.
One very successful strategy involved sending a flyer to schools with the number of a local telephone counseling agency that enrolled callers over the phone. Report card nights had mixed success as did an effort with a local health advocacy project of Einstein Medical Center that wrote letters to families at a middle school offering to assist with enrollment and providing a pizza party to each class that met its enrollment goal. The State funded staff to survey all families at one elementary school and enroll the uninsured. The method proved successful but expensive compared to other methods. The remaining questions for PCCY include:

- will a single application for CHIP and Medicaid make school and community enrollment projects easier or will verification requirements pose a problem?
- will state funding make a difference (currently groups do this without state funding)?
- can evolving partnerships contribute long-term institutionalized solutions?

One participant noted that all outreach efforts build upon each other to generate overall success even if one particular event seems unsuccessful. Another noted the fundamental importance of working with community-based groups since they have the community's trust and recognition. The question was asked if providing an enrollment assistance fee "really works." PCCY offers $25 per application but has no evaluation method in place to see if this increases enrollment. There was mixed response from the group. Some CBOs conduct home visits. In the Southwest, Covering Kids pilots use promotoras to reach the Hispanic population. In rural areas of West Virginia and Alaska, Covering Kids funded outreach workers take laptops and portable printers door-to-door.

Molly Collins, American Hospital Association and Jeannette O'Connor, Children's Defense Fund, Washington, D.C., spoke about their respective organizations' activities in CHIP and Medicaid outreach in **Breakout 9, Other Groups with Outreach Campaigns**. The Children's Defense Fund has offices in six states, Ohio, Texas, California, Mississippi, Minnesota, and New York. In New York, New Jersey and Connecticut, they have partnered with the Kmart Corporation and Martha Stewart Living to sponsor over 50 health fairs at Kmarts. Kmart provided booths for the enrollment assistance and gave $5.00 gift certificates to those applying. In 2000, they plan to approach Kmart in other States. The campaign also included radio and TV spots featuring PSAs starring Martha Stewart. Check **www.childhealthnow.org** for more information on this effort. For states that do not have a CDF chapter, such as Connecticut in this campaign, community-based organizations ran the training and organization of volunteers for the enrollment assistance at Kmart.

CDF has worked with Columbia University to create the Student Health Outreach Project (SHOUT) where college and high school students provide enrollment assistance. SHOUT has been piloted in New York and CDF hopes to expand it to Texas and California. They also plan to begin working with medical students in a similar fashion. A third approach has been holding

outreach events at children's museums. CDF partnered with Merck Pharmaceuticals to sponsor an event at the Children's Museum in Manhattan. Prior to the event, CDF conducted a great deal of outreach to child care centers, housing authorities, etc. to inform them about the enrollment opportunity. Over 2,000 families attended and 430 uninsured children were identified. Local community-based organizations provided enrollment assistance at the museum and medical students also volunteered. Information on this effort should be available in January 2000. Check the CDF website at **www.childrensdefense.org** or contact Ms. O'Connor at 202/662-3653 for more information.

The American Hospital Association has chapters in every state that would be great partners for outreach. In the Washington, D.C. area, AHA partnered with HCFA and HRSA and the local ABC affiliate among others on the "Campaign For Coverage" with local McDonalds. On September 25, enrollment assistance was provided in 16 McDonalds stores in the metro area. AHA purchased air time for promotion, supported materials production, and advertising development for the fall Back-to-School Campaign. The Washington Hospital Association's campaign with the Spokane School District is considered a model for AHA. Ms. Collins suggested that local hospitals and state AHA chapters are great potential outreach partners. Local hospitals are rich in staff resources, they have good community relations staff in place, translation services, and counselors on staff who know eligibility rules for public programs. She is willing to help people find the right group and its website for their respective states.

Participants wondered if there is a national resource to help them understand the multitude of national outreach campaigns they hear about. It was suggested that the HCFA outreach information clearinghouse at www.hcfa.gov/init/outreach/outhome.htm include this information.

Breakout 10, Strategies for Reaching Children Facing Language, Cultural and Geographic Barriers, featured presentations by Rebecca Leiberman, Children's Aid Society, New York; Mary Thorngren and Magdelena Castro-Louis, National Coalition of Hispanic Health and Human Services Organizations (COSSMHO), Washington, D.C., and Cynthia Mala, North Dakota Indian Affairs Council. The Children's Aid Society works with new immigrants to the U.S. trying to connect the entire family, not just the child, to health insurance. The Society has found that school-based enrollment helps them, particularly the school registration process. Key suggestions from the Society for successfully reaching families include:

- having an ongoing and predictable presence in the schools so families know when and where to come for enrollment assistance;
- having dedicated staff in the school for enrollment because existing school staff already have multiple responsibilities;
- sharing information with other school staff so they will support the enrollment efforts;
- using community health workers from the community to work with families;
- ensuring that where you do outreach, you have the capacity to do enrollment at the same time;
- remembering that the most successful outreach is parent to parent information sharing;
- using oral messages instead of written materials; and
- providing health education in general and specifically education about the importance of health insurance and preventive care in the U.S.

COSSMHO noted that the school drop-out rate for Hispanic children is high. The rate starts to climb in middle school so many Hispanic adolescents are not in school and other methods of outreach should be designed to reach them. In order to reach Hispanic children and adolescents it is important to utilize Hispanic community groups because the population respects them and they will be around long-term. Particularly in states with a new influx of Hispanics like Georgia, South Carolina, and Arkansas, the infrastructure of Hispanic community groups does not yet exist and needs to be created. Ms. Thorngren noted that many Hispanic community-based groups feel they have been overlooked in the search for partners for CHIP and Medicaid outreach. These groups would be assets to the planning and implementation process for conducting outreach. They know how to design culturally appropriate outreach and their community workers are trusted. COSSMHO focus groups have found that Hispanic parents like bilingual written materials with bright, colorful letters. Ms. Castro-Louis emphasized that not all Hispanics are the same and that the design of all outreach efforts should involve community members to determine the most effective methods for reaching them.

Ms. Mala explained that there are 2.2 million Native Americans in 550 federally registered tribal nations in 34 states, each with its own culture, language, and history. The Indian Health Service provides health care to Native Americans but it is funded at only 60 to 65 percent of need. Those Native Americans who live off of the reservation face more complications accessing that health care. The most effective way to reach Native Americans is through one-to-one communication and informal gatherings. Working through schools is complicated because there are many levels of government involved--the Bureau of Indian Affairs, the State and/or the tribe. She noted that Healthy Start has some wonderful, culturally competent materials. Ms. Mala expressed her disappointment that few Indian community representatives attended the Summit.

Kristine Hartvigsen, Southern Institute on Children and Families; Polly Sherard, WJLA-Channel 7; Douglas Bauer, Smith Kline Beecham; and Sam Karp, California Health Care Foundation, presented in **Breakout 11, Private Resources to Support Outreach**. The Southern Institute on Children and Families runs the Robert Wood Johnson Foundation's "Covering Kids" Campaign that awarded $47 million in grants to states to conduct outreach. The Institute also conducts studies on issues related to outreach and enrollment for CHIP and Medicaid. Those findings can be found on their website www.coveringkids.org. One study found that many states require more information on their applications than required by Federal regulation. Forty-nine states and the District of Columbia have Covering Kids grants that last three years; South Dakota has not participated but has recently expressed interest in applying. Grantees establish a statewide coalition and two to three pilots that focus on a variety of areas. The pilots will report to the coalition on promising outreach and enrollment strategies with some preliminary results due during the Spring/Summer 2000. These coalitions would be great partners in any State. Contact names can also be found on the website.

WJLA-Channel 7, the ABC affiliate for the Washington, D.C. area, worked with numerous partners including HCFA, HRSA, the American Hospital Association, the March of Dimes, and McDonalds among others, to provide information and enroll children at 16 McDonalds locations in the Washington, D.C. area on September 25, 1999. WJLA's sales and marketing division

works on special projects of public interest including mammography, child immunizations, and a savings campaign. The station has concentrated on CHIP outreach for two years purchasing air time, producing television spots, broadcasting local events during newscasts, holding a phone bank and establishing an 800 number for information. They also partnered with Safeway to place an announcement in their Sunday advertisement, wrote State-specific press releases for the September 25th event and developed back-to-school supplies to be given to families. WJLA looks to find partners to leverage other partners who have similar goals to create these public interest campaigns. Local television stations across the country also have the potential to engage in these types of activities. Contact Polly Sherard at 202/364-7925 for more information on developing such a partnership.

Smith Kline Beecham is the largest producer of vaccines and an active funder of community-based health care, supporting education and advocacy. The pharmaceutical company funds direct services and granted $2.9 million to 140 communities to promote a healthy start for each child in the community. Like WJLA, Smith Kline Beecham likes to leverage their contributions to find additional resources from similarly focused organizations to achieve their public health goals.

The California Health Care Foundation works to develop new technologies and business processes to streamline health care. The Foundation worked with the State of California to develop a program to accurately determine family size and income, based on a Turbo Tax model. They did not use a State procurement process. Instead, once the software was developed, if the State decides to use it, the Foundation will lease it to the State for $1 per year. The Foundation is currently field testing a web-based application for Medi-Cal and Healthy Families. If the web-based application determines Medi-Cal (Medicaid) eligibility, the application, with signature page and verifications, are sent to the county Medicaid office for a determination. For additional information about how this process works, contact Sam Karp at 510/238-1040.

Patricia Stromberg, Pennsylvania Department of Insurance and Denise Dougherty, Agency for Health Care Policy and Research presented their experiences evaluating outreach in **Breakout 12, Evaluating Outreach**.

Questions to consider in conducting outreach:

- Do we know who the eligible children are?
- Do we know how well the programs address the relevant needs that families feel are important?
- Do we know how eligible families view the concept of insurance, economic opportunity costs, obtaining preventive care services and having continuity of care?

Ms. Stromberg stated that outreach approaches among States are not unique and that all States are trying to identify what the marketplace looks like. CPS data on a statewide basis does not yield accurate enough information about the population so the State is putting other indicators into place that will lead them to measure how well they are doing in reaching and enrolling the eligible population. Pennsylvania's program conducted State-wide media blitzes during selected shows over 6 weeks resulting in 33,000 calls. They have been able to determine where calls

come from in relation to where ads are placed, they can unduplicate calls and they can determine the number of calls answered by each operator. Their future plans include developing data sources to find out how people learn about the programs and creating a central database. Contact Ms. Stromberg at 717/705-0542 for further information on what Pennsylvania has been doing to evaluate its outreach activities.

Denise Dougherty of AHCPR asked "why evaluate outreach?" Evaluating outreach methods is important so that resources are spent on cost-effective methods that result in the largest number children enrolling in health insurance programs. AHCPR is the nation's leading health services research agency, and the agency focuses on outcomes, quality, cost, use, and access to care. In a recent partnership with the Packard Foundation and HRSA, AHCPR awarded 9 grants that will answer research questions about insurance dynamics for low-income children.

In addition, AHCPR, with support from the Assistant Secretary for Planning and Evaluation, DHHS, has a contract with Barents Group LLC to report on the various methodologies that have been used to evaluate outreach and the outcomes of those evaluations. The final report will be completed in late winter 2000. Copies of that report can be requested from Peggy McNamara at 301/594-6826 or Denise Dougherty at 301/594-2051. Outcome measures that have been identified include the number of calls placed; number of applications submitted; number of applications approved; number of enrollees per broker per week; number enrolled in Medicaid; and number enrolled in CHIP. Ms. Dougherty identified a number of intervention and non-intervention studies underway. The intervention studies include ones in Connecticut, Michigan, Arizona, and California. AHCPR's next steps include efforts to resolves the lack of comparison groups, the dirth of pre-post data collection; the lack of denominator information, and the variation among data sources.

State Meetings

The second morning of the Summit states were asked to meet as teams to discuss a series of questions:

- Have school-based strategies been employed in the state? What are they?
- What practices seemed to be effective? How were these evaluated?
- What could the State/schools do to enhance school-based outreach efforts? What new initiatives might be successful in your State?
- What goals could the State/schools set, and how would they determine their success?
- What resources would be helpful or necessary to carry out these activities? Does your organization or your state have resources that the other states should know about?
- What barriers still exist to making school-based outreach a part of "business as usual" in your state?
- What technical assistance might be helpful? From whom?

Advocates Meeting

Concurrent with the State meetings, representatives of national organizations met to discuss school-based outreach. Their ideas and suggestions include:

- Establishing an email listserv for the effort;
- State agencies and organizations need to find out who is involved in this effort in their State;
- Efforts need to be sustainable and cannot require many resources in order for schools to implement them;
- National organizations could help identify States and districts that are not participating and help promote partnerships;
- Being advocates for schools because this is not necessarily part of their mandate;
- Establish access to databases so efforts are not being duplicated, particularly for school meals and CHIP/Medicaid;
- Remember that many adolescents are not in schools so special approaches need to be created;
- Need to identify local people to carry this out—involve the HRSA regional and State networks, Maternal and Child Health staff, AMCHP, NACCHO, NCSL, and the American Bar Association;
- Share the social marketing research conducted by NASTHO;
- Focus on foundations for resources in States where outreach is on hold until funds are allocated;
- Establish a way to have school-based health services reimbursed by CHIP; and
- Work on portability of coverage for migrant populations.

Wrap Up Session

Most states had the opportunity to report out their answers. The major themes and suggestions made in their reporting out and the advocates meeting were compiled for a wrap-up session delivered by **Kansas City HHS Regional Director Katie Steele**.

What are organizations doing that seems to work for school-based outreach?

- Providing one-on-one follow up with families.
- CHIP/Medicaid applications are being included in school newsletters and flyers.
- State legislatures are requiring schools and health departments to coordinate on outreach.
- Peer to peer outreach models are being developed (e.g., SHOUT).
- Nurses, coaches, teachers and counselors are involved.
- Report Card Days.
- Insuring the whole family.
- Targeted messages for different audiences.
- Kindergarten enrollment, sports enrollment, Head Start enrollment fairs are good venues.
- Information releases are incorporated in school meal applications.
- Special education and other program administrators and teachers are partners in outreach and enrollment.
- Toll-free numbers are in place.
- Trying to “hit” target audiences several times to get the message across.

How are these efforts being evaluated?

- Formally setting targets for both CHIP and Medicaid enrollment.
- Measuring by applications returned and calls to hotline.
- Using a source code on applications instead of color coding them.

- There is a lot of effort but not much measurement yet.
- Still trying to identify the uninsured children and set a percentage by district.
- Working on building personal relationships, especially in rural areas.

What could organizations do to enhance school-based outreach efforts?
- Need more coordination with school lunch programs.
- Need a schedule of key promotional activities.
- Need an ad campaign targeted at schools.
- Need to train more school staff in outreach and enrollment or have dedicated staff in schools.
- Need to put information on CHIP/Medicaid outreach in school nurses association newsletter.

What resources do States need? Do you (does your organization) have resources/materials that the other organizations or States should know about?
- Need administrative match dollars for CHIP outreach.
- Need money specifically for school-based outreach.
- Want the money spent on outreach separated from the 10 percent cap.
- Want help developing webpages to link databases.

What can organizations do to eliminate barriers that still exist to making school-based outreach a part of "business as usual"?
- Need to recognize that schools have competing priorities and that this is another unfunded mandate.
- Need to address the general lack of awareness among schools.
- States do not know about the various ad campaigns. Often times they send mixed messages and compete. More coordination of these is needed.
- Immigrant children and families are especially hard to reach. Culturally appropriate materials need to be developed.
- Mixed messages seem to be sent. The Federal government is saying do school-based outreach at the same time that HCFA makes it harder to get reimbursement for services through schools.
- Want the Federal government to resolve data sharing and confidentiality issues across their programs.
- Want to be able to cover Medicaid with CHIP money.
- Want a pilot on presumptive eligibility.
- Study the waiting period to see if it really prevents crowd out and is necessary.

What technical assistance would be helpful? Can organizations provide this?
- Cultural competency training.
- Want information on best practices via the web.
- Want more leadership from the U.S. Department of Education explaining to their constituencies that this is important.
- Need more funding than the 10 percent administrative limit.
- Need more networking, regional meetings and opportunities for cross-pollenization.

- Need a common database of HCFA policy decisions, plan amendments, Qs and As.
- Need a Federal fix on the school-lunch information sharing issue.
- Need research showing the effect of health insurance on school performance.
- Need a web-based application. Want clearance from HCFA on electronic signature.
- Need more data sharing and tracking mechanisms and shared databases.
- States need help developing mechanisms to evaluate outreach efforts.
- Clarify the issue of employer contributions for family coverage.
- Create standard definitions for family size and income.
- HCFA needs to enforce the Outstationed Medicaid Eligibility Worker requirement for FQHCs and DSH hospitals.

Closing Session

Christopher Jennings, Deputy Assistant to the President for Health Care Policy spoke during the Summit's Closing Session. He noted that the presence of four Cabinet Secretaries is unprecedented and illustrates this Administration's commitment to providing health insurance to all Americans. He continued that the Clinton Administration has focused on targeted reforms along the way to universal coverage because of a political climate where universal coverage is not a possibility. For that reason, the SCHIP legislation was pursued and passed. Mr. Jennings noted that the U.S. is at a crossroads in health policy and the nation has three choices: to deny the current situation and continue in the same manner as we have; to continue to change the system by building on what works in the current system; or to start over with a new system entirely, which is appealing but unlikely. He closed by discussing the importance of current health issues like presumptive eligibility for Medicaid, interagency cooperation at the State level, the use of the 10 percent administrative funds in CHIP and the use of the $500 million TANF funds.

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